CHAPTER OVERVIEW

This chapter addresses the medical/mental health planning process and legal basis for the provision of medical and mental health services to children in the legal custody of the Children's Division. Routine medical care, life support/sustaining therapies, and HIV/AIDS issues are discussed. This chapter also establishes a protocol to be used in determining which Children's Division (CD) families involve children who have been placed in custody due solely to a need for mental health services and where no instance of parental abuse, neglect, or abandonment exists. Also, included in this chapter are procedures for responding to the death of a child in the legal custody of the Children's Division.

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24.1 Legal Basis for the Provision of Medical Services

The legal basis for the provision of medical services comes from the following Missouri statutes:

207.020(17) To accept for social services and care, homeless, dependent and neglected children in all counties where legal custody being vested in the Children's Division by the juvenile court where the juvenile court has acquired jurisdiction pursuant to subdivision (1) or (2) of subsection 1 of section 211.031, RSMo;

208.204.2. Through judicial review or Family Support Team meetings, the Children's Division shall determine which cases involve children in the system due exclusively to a need for mental health services, and identify the cases where no instance of abuse, neglect, or abandonment exists.

208.204.3. Within sixty days of a child being identified pursuant to the above, an individualized treatment plan shall be developed by the applicable state agencies responsible for providing or paying for any/all appropriate services-subject to appropriation- and the Department of Social Services shall submit the plan to the appropriate judge of the child for approval. The child may be returned by the judge to the custody of the child's family.

208.204.4. When the children are returned to their family's custody and become the service responsibility of the department of mental health, the appropriate moneys to provide for the care of each child…shall be billed to the department of social services by the department of mental health pursuant to a comprehensive financing plan developed jointly by the two departments.

210.720(2) In such permanency hearings the court shall consider all relevant factors including; (3) The mental and physical health of all individuals involved, including any history of abuse of any individuals involved;

210.760 In making placements in foster care the Children's Division shall: (2) Provide full and accurate medical information and medical history to the persons providing foster care at the time of placement;

210.002 Year 2000 Plan requires The Children's Division (CD) to participate in the development and implementation of coordinated social and health services which includes preventive, maintenance and long-term medical and mental health care.

24.2 Medical Information to be Obtained When Child Enters Care

1. The Children's Service Worker will ensure that initial medical information is obtained from the parent/physician and given to the foster parent within 72 hours, if possible, but no later than 30 days following placement. This information should include:

   a) Immunization history;

   b) Past and current medical problems;

   c) Allergies and adverse reactions to medications;

   d) Hospitalizations and surgeries;

   e) Dental records;

   f) Current medications;

   g) Current and past medical providers;

   h) Developmental milestones;

i) Prenatal and birth history;

j) Current and past illnesses;

k) Psychological services - past and current;

l) Nutritional history;

m) Environmental issues which may pose health risk, i.e., exposure to lead;

n) Mother's use of alcohol/drugs during pregnancy; and

o) Risk factors contributing to potential exposure to HIV/AIDS.

2. The Children's Service Worker shall establish and maintain a medical record (separate and distinct section in the file or separate record) on each child in care. In order to ensure continuity of care, this record shall include copies of the initial medical examination report and ALL existing medical records on the child, including both current and past medical information.

Also included in the medical record should be a copy of the log of illnesses, medications and the amount given, visits to physician/therapist and the purpose of the visit. The medical log should be kept by the placement provider and submitted to the Children's Service Worker for inclusion in the child's record on a monthly basis.

Related Subject: Section 5, Chapter 1, Documentation and Record Maintenance.

3. A summary of the child's medical history including any recent illnesses, and the name and dosage of medication currently taken by the child shall be passed on to the new resource, in writing, whenever a change in placement occurs.

4. The initial health examination shall occur within 24 hours of the child coming into care. If possible, this initial examination should be a complete HCY screening (physical, eye, hearing, dental examinations). If only a partial screening (physical examination) can be completed within 24 hours, eye, hearing and dental examinations shall occur within the first 30 days the child is in care.

5. Ongoing medical care should be obtained in accordance to the HCY examination/immunization schedule.

6. All information about the child's medical care while in out-of-home care shall be shared with the parent/caregiver on an ongoing basis. A copy of the complete medical history should be furnished to the parent/guardian.

7. The Children's Service Worker shall ensure that all children receive education on sexual development, appropriate to their age, life experiences, and living conditions. This education should include information on birth control and venereal diseases. Birth control should be made available to all children that are sexually active. All efforts to comply with this policy must be clearly documented in the record. Parents should be involved in the decision, and if in disagreement, the worker should get court approval.

8. In order to prevent further spread, unnecessary avoidance, and embarrassment, resources and information shall be made available to all parties involved with children that have communicable diseases, parasites, sexually transmitted diseases or test positive for HIV exposure.

9. The Children's Service Worker shall ensure that children with serious emotional and behavior disturbances receive appropriate counseling, therapy and/or medication. Also, the Worker must ensure that the placement provider has the knowledge and skills necessary to provide appropriate care for the child.

24.3 Medical Service Alternatives/Planning

Medical planning for children in out-of-home care is a necessary service to ensure that children receive the medical care they need. The following includes several medical service alternatives for which planning will be necessary:

24.3.1 Routine Medical/Dental Care

Routine medical/dental care including services available through the Healthy Children and Youth (HCY) Program, also known as Early Periodic Screening, Diagnosis and Treatment (EPDST).

- Children entering out-of-home care need initial medical examinations, as well as regular medical examinations throughout their out-of-home care placement.

- Plan with out-of-home care providers and other appropriate team members to ensure that all children in out-of-home care shall receive education on sexual development, appropriate to their age, life experiences, and living conditions. This information should include information on sexuality and venereal diseases.

- Children in out-of-home care are eligible for MM/DSP (Medicaid, Title XIX). As a result, they are also eligible for HCY services.

24.3.2 Human Immunodeficiency Virus (HIV) Screening

HIV Screening (ELISA test) is available for children entering out-of-home care who are displaying symptoms of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or at increased risk of AIDS. The Children's

Services Worker may arrange for the ELISA test through the local Health Department or a private physician. The ELISA test is covered by MM/DSP.

24.3.3 Emergency and Extraordinary Medical/Dental Care (over $500.00)

When children are in CD custody their birth parents still have certain rights. One of these rights is to give permission for extraordinary medical/dental care. Whenever possible, the worker should seek parental permission for these medical/dental services. If this is not possible, the Children's Services Worker shall seek approval for the medical/dental services from the juvenile court. Then the Children's Service Worker shall seek approval through their Area Office.

24.3.4 Children's Treatment Services

Children in Out-of-home care are eligible for a variety of children's treatment services, medical and psychiatric services covered by a contract with CD. If a child in out-of-home care is in need of these services, the worker should consult the listing of CD approved contractual treatment providers who offer the service and make the appropriate referral. Payment will be made at Medicaid or state contracted rates.

NOTE: For medical examinations, the HCY referral should be done first. CTS would be used if an HCY physician is not available.

24.3.5 Missouri Medical/Dental Services Program (MM/DSP) (Also known as Title XIX or Medicaid)

Children in out-of-home care are eligible for MM/DSP if they are in the custody of CD. Guidelines established by the Division of Medical Services determine which medical services are eligible for payment and at what rate. Staff should use this program whenever possible to provide a child with medical care. HCY services are available through this program.

24.3.6 Bureau for Children With Special Health Care Needs (BCSHCN)

This bureau provides some medical services not covered by Medicaid. To make a referral for a child, the Children's Service Worker should make sure that the needed medical services are not covered by Medicaid. When it has been determined that the needed medical services are not covered by Medicaid, the Children's Services Worker may make a referral to the appropriate regional bureau office.

24.3.7 Department of Mental Health

The Department of Mental Health (DMH) provides mental health services to children who are determined to be eligible for the services. Children in Out-of-home care and who are in need of mental health services may be referred to the

appropriate DMH facility determined to meet the needs of the child. Three separate DMH divisions deal with the following:

- Comprehensive psychiatric services;
- Mental retardation and developmental disabilities; and,
- Alcohol and drug abuse.

It is important to make the referral to the Division that deals with the specific mental health need. For more information on referral procedures, contact the DMH facility in the catchment area serving the geographical area in which the child lives. See Section 24.4.

24.3.8 Residential Care Referral

Children in Out-of-home care and in need of residential treatment should be referred to their area RCST Coordinator via the CS-9.

24.3.9 Private Psychiatric Hospital Placement

Children in Out-of-home care who are eligible for private psychiatric hospital care. These facilities provide services including medical treatment, psychiatric/psychological counseling and testing, nursing care, educational services, social work services, recreation services and occupational therapy. The Children's Services Worker should contact the hospital directly to arrange for the child's admission. Cost for the child's care is paid by Medicaid for a number of days as prescribed by the Professional Activity Study (PAS).

Payment for days beyond the PAS days may be paid with Area Office approval. The psychiatric facility should request prior approval of the extension through the Division of Medical Services (DMS) for extended Medicaid payment of the service. If DMS denies, the psychiatric facility should submit the request for payment to the County Office. Such a request is forwarded through normal supervisory channels to the Program Development System Unit (PDSU). The worker should consult the listing of CD contracted services and use these facilities, if treatment is anticipated to exceed the number of PAS days.

24.3.10 Medical Foster Care

Children in Out-of-home care who require special care directly attributable to a medical/physical/developmental disability may be eligible to receive medical foster care. If a child is in need of such special care, refer the child through supervisory lines for the Area Director's approval. The referral must include form CS-10 and written documentation of the child's problems and the involvement of the foster parents in caring for the child, if applicable.

Related Subject: Chapter 15, of this section, Medical Foster Care.

24.4 Identification of Children in the Custody of the Children's Division Solely for the Purpose of Accessing Mental Health Services

Parents should not have to relinquish custody of their child due solely to a need to access clinically indicated mental health services. Children in custody for that reason and absent a probable cause or preponderance of evidence CA/N finding may be eligible for return to the custody of their parents through a protocol established by the passage of Senate Bill 1003 (SB 1003) during the 2004 legislative session.

1. Supervisory Review of Children Who May Meet the Criteria for SB 1003

Children who have entered Children's Division custody, absent a probable cause or preponderance of evidence CA/N finding, should be carefully reviewed to determine if they meet the criteria within SB 1003.

The review of a child in CD custody and determination of meeting SB 1003 criteria must include the following:

- Is the child in the custody of the Division solely because the parents were unable to access or afford mental health needs of the child?
- Is the parent verbalizing a desire for the child's return to his/her custody if the child could receive the necessary mental health services?
- Would the child's safety or the safety of others in the home be compromised by such a return of custody?

Should the parent of a child not previously identified as potentially meeting the eligibility criteria contact the CD expressing a belief that his/her child indeed meets these criteria, CD staff will respond to the request and inform the parent that an FST meeting will be convened within two weeks of the parent's request.

2. Convening the Family Support Team

Once the review is completed and it appears that the reason for the initial placement may be due *solely* to a need to access clinically indicated mental health services, a Family Support Team (FST) meeting is to be convened by the CD case manager upon agreement with the child's parents. This FST meeting should be scheduled and held within 2 weeks in order to begin the process for further assessment and planning. Current policy for FST meetings is to be observed in keeping with the requirements of Section 4, Chapter 7 of the Child Welfare Manual. It is crucial that the child's family be actively involved in the FST and planning process. The case record

should clearly document if the family states they are not yet ready to regain custody.

Additional and crucial FST participants shall include:

- The local representatives of the Department of Mental Health's (DMH) Administrative Agents and/or DMH Regional Center staff; and
- Representatives of current placement and treatment providers.

If the child has developmental issues that can best be served by MR/DD within DMH, this agency should be actively involved in the planning process.

The focus of the FST meeting is to jointly determine if the child's placement in CD was due *solely* to a need for mental health services **and** was unrelated to parental abuse, neglect, or abandonment.

If consensus is **not** reached by the FST on whether the child meets the eligibility criteria, the child shall be considered inappropriate for the Senate Bill 1003 protocol. This, however, should not exclude other efforts toward reunification or further steps to obtain clinically indicated services or supports through DMH.

3. Development of an Individualized Plan to Return the Child to the Custody of the Parent and Request for a Court Hearing

If the FST agrees that the family meets the criteria for SB 1003 and the parent desires to have the child returned to his/her custody, an individualized plan shall be developed which outlines all services and supports needed by the child and family and identifies who shall be financially responsible for each.

The child, if appropriate, and the family shall actively participate in the plan's design. Identified services shall be provided in the least restrictive and most normalized environment. Treatment services and supports shall include but not be limited to those which are home and community based.

This plan shall be submitted to the court within sixty (60) days of the child having been identified through consensus of the FST. The judge may then return custody of the child to the parent.

4. Payment for Services Provided to the Child and Family Once Custody Has Been Returned to the Parent

208.204.4: When children are returned to their family's custody and become the service responsibility of the Department of Mental Health, the appropriate monies to provide for the care of each child in each particular situation shall be billed to the Department of Social

Services by the Department of Mental Health pursuant to a comprehensive financing plan developed by the two departments.

The Children's Division is committed to assuring that the child and family continue to have access to those services that help them meet the needs of the child. If the Division previously paid for such services, it will continue to do so. It is not necessary for the child to be returned to the home of the parent in order for custody to be transferred. To that end, the Division will continue to fund residential treatment if the child continues to need that service as identified through the individualized treatment plan.

Staff should contact the payment unit in Central Office (573-751-8946) for assistance in payment to placement providers for any youth in need of continued residential placement but no longer in the Division's legal custody.

5. Ongoing Implementation of SB 1003

For youth who meet SB 1003 criteria and are not otherwise diverted from CD custody, staff should implement the above protocol as quickly as possible to help expedite the youth's return to the custody of his/her parents. The issues relating to the child's placement should be addressed as early as the initial 72- hour FST meeting. The representation of DMH and the current placement provider(s) should be brought into the FST process as soon as possible to assist in the service planning.

Within sixty (60) days of a child being identified as appropriate for the provisions of SB 1003, an individualized treatment plan shall be developed by the FST, and the Children's Division shall submit the plan to the juvenile/family court judge for approval. The child may be returned by the judge to the custody of his/her family.

24.5 Pregnancy of Child in Out-of-Home Care

Should a child become pregnant while in foster care, all efforts should be made to ensure complete prenatal care is received. In addition, the court of jurisdiction should be notified of the youth's pregnancy. The Children's Service Worker should refer the youth to appropriate persons for information and resources needed to explore her options, i.e., giving birth and caring for the child, giving birth and relinquishing parental rights for the purpose of adoption, etc. The child should make an informed decision without undue influence and/or coercion by the Division, placement provider or parents. If the youth elects to terminate the pregnancy, parental consent is required. If the parents fail to consent, the court must issue an order that the youth is making an informed decision. If the child elects to give birth and care for the infant, every effort must be made to keep the child and infant together. The Worker must refer the child and infant to the Eligibility Specialist, utilizing form CS-IV-E/FFP1. The Worker shall carefully document the child's progress and any contact regarding the health of the child and infant in the case record.

Related Subject: Chapter 11, of this section, Attachment F, Children of Youth in Alternative Care.

24.6 Chemical Dependency Treatment

Adolescents often experiment with the use of drugs and/or alcohol and should be provided with education regarding the consequences of such behavior and support in stopping the behavior, particularly if the child comes from an alcohol/drug addicted family environment.

Chemical dependency treatment will be explored when a child is motivated and demonstrates a willingness to participate in treatment. The value of chemical dependency treatment must be carefully assessed when the child has a history of repeated failures in treatment, and there is no substantial change in their circumstances or behavior since their dismissal from the previous program. Under these circumstances, the appropriateness of a specific treatment program should be questioned if the program does not offer aftercare services.

To the extent possible, the best possible treatment must be provided in the child's community of residence, i.e., community C-Star program operated by the Department of Mental Health.

24.7 HIV/AIDS Issues

Screening for HIV/AIDS shall occur for children in the following high risk groups:

- Infants born to mothers known to be HIV antibodies positive or who are known to be HIV carriers.
- Hemophiliac youths who received blood or blood products before May 1985.
- Children who have had sexual contact with or who have shared IV needles with persons who are known to be HIV antibodies positive or who are known to be HIV carriers.
- Children whose medical symptoms or sexual histories indicate the possibility of exposure to HIV carriers.

NOTE: Screening results are reliable only for "a moment in time" and do not establish whether a child has been exposed to HIV/AIDS.

The request for HIV/AIDS screening and the results of the screening should be handled in a discreet, confidential manner. The child's Children's Service Worker and placement resource should be advised when there is a positive screening result. In order to assure that confidentiality and the child's right to privacy is protected, other persons involved (Guardian ad Litem, juvenile court, biological parents) will be notified on case-by-case

and need-to-know basis. As few people as possible should be notified, depending on the circumstances of the case.

Children who are known to be HIV antibodies positive or HIV carriers and their placement provider should receive specialized counseling services and support to help them deal with the ramifications of the disease and to make plans for the possible deterioration in health.

24.8 Life Support/Sustaining Therapies

The Division Director will make the decision regarding the agency's recommendation on the use of life support systems and life sustaining therapies. This decision will be made in consultation with the child (if mentally and physically capable of making the decision), biological parent, juvenile court, the child's physician, the child's Children's Service Worker, care provider, and at least two physicians who have access to the child and the child's records. The final decision regarding the use of life support shall rest with the court.

A child with a life threatening illness should be given the option of making a living will. The subject of making a living will should be discussed with the child by someone comfortable with and knowledgeable about death issues. CD should provide the legal mechanism for the writing and filing of the document. Copies of the living will should be distributed to the juvenile court, Guardian ad Litem, physician, hospital, biological parent and a copy filed in the child's record.

NOTE: Life sustaining therapies are defined as tube feeding, respirator, physical therapies to sustain life, intravenous fluids (IV), etc.

When county office staff is confronted with situations which require the continued use of life support systems or the removal of life sustaining therapies from children within the care and custody of the Children's Division, staff shall:

1. Immediately gather appropriate identifying and medical information including:

   a) Condition and prognosis of the child;

   b) Other pertinent information regarding the child, i.e., age, birth date and location;

   c) Parent(s) name and address; if there is no parent(s), then the nearest kin;

   d) Most recent court order; and

   e) Other appropriate medical and identifying information.

2. Notify Area Director immediately, via telephone, and provide an explanation of the child's situation and appropriate information based on Step 1.

3. Notify the birth parent(s)/kinship.

4. Notify the juvenile office and/or juvenile court immediately if medical facility does not provide all appropriate information or there is a concern for the child's health while a review is being conducted.

5. Immediately submit, a written report containing the information outlined above to the area director.

6. Before, during, and after the decision has been made to begin or discontinue life support systems, establish open communications with the birth parent(s), foster parent(s) and sibling(s) of the child.

7. County office staff will update area director, as necessary, on any changes in the child's condition during the review process.

8. Assist the family by providing or arranging contact with support groups, counseling or any other service necessary to aid the family in the event of the child's death.

Upon notification the Area Director will:

1. Call and advise the Deputy Director of Children's Services of this medical emergency, relaying the information concerning the child's case as provided in the required staff report.

2. Forward immediately, upon receipt, a copy of the written report containing the information outlined above to the Deputy Director/Children's Services.

Upon notification the Deputy Director of Children's Services will notify the Director of CD, of the situation and provide all known information related to the child's medical condition.

The Director will:

1. Provide this information to the Director, Department of Social Services.

2. If appropriate, consult with the court of jurisdiction, Department of Social Services personnel and other persons and agencies concerning the decision to continue or discontinue life support or life sustaining care beyond emergency medical services.

3. Refer the medical information to an ad hoc committee of three (3) doctors who will review same and make a recommendation to the director. Assistance will be sought from the Division of Legal Services, when necessary.

24.9 Death of a Child in Out-of-Home Care

The child's death will have a profound impact on the parent and placement provider. The family Children's Service Worker should be particularly sensitive to their loss and offer appropriate support.

When death occurs of a child in CD care and custody, placed in out-of-home care, the family Children's Service Worker shall work with the biological family regarding burial arrangements and expenses. If the biological family is willing and able to assume responsibility for the burial, they should be encouraged to do so. The family worker shall explore resources such as insurance policies, Social Security and other benefits.

If the biological family is not able to assume responsibility, the family Children's Service Worker shall contact a local funeral home to provide a dignified burial within the acceptable standards of the community. To the extent possible, consider the wishes of the biological and foster family in making arrangements for the child's burial. Payment will be made from state office foster care special expense funds using the CS-65. An itemized list of expenses will need to be attached to the CS-65.

If the child died under suspicious circumstances, the Children's Service Worker shall file a report with the Central Registry Unit.

If the child was less than 18 years of age, the family Children's Service Worker will need to determine if the coroner or medical examiner has been notified under the provisions of Missouri statutes 58.452 and 58.772, RSMo. If notification has not been made, the family Worker will need to notify the coroner or medical examiner of the child's death. The coroner or medical examiner will, if appropriate, contact the chairman of the Child Fatality Review Panel.

If the child was 18 years of age or younger, the family Children's Service Worker will need to determine if the coroner or medical examiner has been notified when there is reasonable ground to believe that the child died as a result of:

- Violence by homicide, suicide or accident;
- Criminal abortions, including those self-induced;
- Some unforeseen sudden occurrence and the deceased had not been attended by a physician during the 36 hour period proceeding the death;
- Any injury or illness while in the custody of the law or while an inmate in a public institution.
- In any unusual or suspicious manner;

The family Children's Service Worker shall gather and document in the case record, all pertinent facts regarding the child's death including:

- Cause of death;
- Time of death;
- Location of death; and
- Circumstances surrounding the child's death and any witnesses.

The circumstances of the child's death will assist the family Children's Service Worker to determine which sources to contact for this information. The family worker shall contact the following persons as appropriate:

1. Immediately notify the juvenile office and/or family/juvenile court of jurisdiction and the Guardian Ad Litem and/or CASA.
2. Verbally notify the Deputy Director, Children's Services, through supervisory channels, of the child's death. This notification shall occur immediately.
3. Personally notify the biological parents of the child's death. This notification is to occur immediately. If the biological parents reside in another county or out of state, the family Children's Service Worker shall request assistance from the worker in the other county or state to make personal notification.
4. All persons who have knowledge of the circumstances should be contacted. This may include physicians, police, placement providers, school personnel, witnesses, etc.
5. Submit a Report of Death or Serious Injury (CS-23) to the Deputy Director, Children's Services, through supervisory channels within five (5) working days of knowledge of the child's death.
6. Provide the coroner/medical examiner and funeral home information for completion of the death certificate.
7. Any agency the child was receiving benefits from such as SSI, VA, insurance companies, etc. A copy of the child's death certificate may be provided upon request.
8. The eligibility specialist so that the child's KIDS account can be closed.

MEMORANDA HISTORY: